Medical History Form

Please help your pharmacist keep an up to date record of your health. Please fill in as much as you can. This information will be kept confidential. Today's Date: ________________________________

1. Patient Information:

Name: ____ Birth Date: ____________________________

Address: ______________________________ City: __________________________ Postal Code: ______________

Home/Work Phone #: ____________________ Email address: ________________________________

Gender: Male Female Height: ______ Weight: _____

Do you have drug coverage? ☐ NO ☐ YES If yes, what company? ________________________________

Group Number _________________________ Identification Number _______________________________________

2. Doctor Information: Are you currently under the care of a physician? ☐ NO ☐ YES
If YES, please list each doctor from whom you seek care, including address and phone number, if known:

Doctor name: __________________________ Address: _______________________ Phone: __________________

Doctor name: __________________________ Address: _______________________ Phone: __________________

Doctor name: __________________________ Address: _______________________ Phone: __________________

3. Lifestyle Information:	
Please check all that apply.	**Pharmacist's Comments**
Caffeine use: ☐ None In cups per day: ___coffee ___tea ___cola	
Cigarette use: ☐ None ___Packs per day or ___Cigarettes per day ☐ Former smoker: Date quit ________________ Are there smokers in your household? ☐ NO ☐ YES	
Alcohol use: ☐ None ☐ Under 2 drinks per day ☐ Over 2 drinks per day	
Drugs of abuse: ☐ None ☐ Occasional ☐ Regular Specify:	
Do you have a MedicAlert bracelet, necklace, etc? ☐ NO ☐ YES	
Do you follow a special diet? ☐ NO ☐ YES Specify:	
Exercise program: ☐ None ☐ Occasional ☐ Regular	
Are you currently pregnant or breast-feeding? ☐ NO ☐ YES If YES, Due date:	

Do you have problems with: • Eyesight…………… ☐ NO ☐ YES ☐ Glasses/Contact lenses • Hearing…………….. ☐ NO ☐ YES ☐ Hearing Aid • Opening drug vials…..☐ NO ☐ YES • Remembering to take your medicine……….☐ NO ☐ YES Getting to the drugstore to fill/refill your medicine….☐ NO ☐ YES Reason:	
Do you stop taking your medications when you feel better? ☐ NO ☐ YES	
Do you stop taking your medications when you feel worse? ☐ NO ☐ YES	
Did you ever not take any of your prescription medications because they were too expensive? ☐ NO ☐ YES	

4. Allergies:			
Please check all that apply.			**Pharmacist's Comments**
☐ Penicillin	☐ Nitrate allergy	☐ Farm Sprays	
☐ Codeine	☐ Dye allergies	☐ Dust	
☐ Sulfa drug	☐ Seasonal (pollens)	☐ Molds	
☐ Morphine	☐ Animals	☐ Sulphites	
☐ Aspirin	☐ Smoke	☐ No known allergies	
☐ Other:			
Please describe the allergic reaction you experienced when it occurred:			

5. Immunization History:	
Please check all vaccines that you have received.	**Pharmacist's Comments**
Have you had any of the following vaccines? ☐ Influenza vaccine (flu shot) Date last received: _______________ ☐ Pneumovax Date last received: _______________ ☐ Other (specify): ______________Date last received: _______________	

6. Prescription Medications:

Please list all prescription medications you are currently using. Be sure to include physician samples.

Medication Name	Strength (how much e.g. 10mg)	Form (e.g. pills, patch, etc.)	How Often (e.g. times/day)	Reason for Use	Concerns?
1.					
2.					
3.					
4.					
5.					
6.					

7. Over-the-counter (OTC) issues:	
Please check all products that you use occasionally or regularly.	**Pharmacist's Comments**
□ **For Pain Relief** (e.g. Tylenol ®, Robaxacet®, Norflex®, Aspirin®, Anacin®, Asaphen®, Advil®, Motrin®, Myoflex®, Bengay®)	
□ **For Cough/Cold/Congestion** (e.g. Robitussin DM®, Buckley's DM®, Koffex DM® Triaminic DM®, Sudafed®, Sinutab®)	
□ **For Allergy Relief** (e.g. Chlor-Tripolon®, Benadryl®, Claritin®, Reactine®, Allegra®)	
□ **For Constipation** (e.g. Soflax®, Senokot®, Dulcolax®, Ex-lax®, Correctol®, Metamucil®, Prodiem®, Milk of Magnesia)	
□ **For Diarrhea** (e.g. Imodium®, Kaopectate®, Pepto Bismol®)	
□ **To Sleep** (e.g. Excedrin PM®, Sominex®, Nytol®, Sleep Eze D®, Sleepaid®)	
□ **To Stay Awake** (e.g. Wake Ups®, Stay Awake®)	
□ **For Weight Loss** (e.g. Dexatrim®, GL-100®, Trim Fit®, Proenzi 99®)	
□ **For Your Stomach** (e.g. Maalox®, Mylanta®, Dioval®, Gavison®, Tums®, Rolaids®, Milk of Magnesia, Pepcid AC®, Zantac 75®)	
□ **For Your Skin** (e.g. Gold Bond®, Lanacane®, Ozonol®, Cortoderm®, Aveeno®, Hibitane®, Polysporin®)	
□ **To Help Quit Smoking** (e.g. Nicorette®, NicoDerm®, Habitrol®)	
□ **Others** (please specifiy):	

8. Nutritional/Natural Supplements:	
Please identify and list the products you are using:	**Pharmacist's Comments**
Vitamins (e.g. multiple or single vitamins such as B complex, E, C, beta carotene):	
Minerals (e.g. calcium, magnesium, chromium, colloidal minerals, various single minerals):	
Herbs (e.g. Ginseng, Ginkgo Biloba, Echinacea, other herbal medicinal teas, tinctures, remedies, etc.):	
Enzymes (e.g. digestive formulas, papaya, bromelain, CoEnzyme Q10, etc.):	
Nutrition/protein supplements (e.g. shark cartilage, protein powders, amino acids, fish oils, etc.):	
Others (glucosamine, etc.):	

9. Medical Conditions/Diseases:	
Please check all that apply.	**Pharmacist's Comments**
Heart disease (e.g. Congestive Heart Failure, Angina)	
High cholesterol or lipids (e.g. Hyperlipidemia, Dyslipidemia,)	
High blood pressure (e.g. Hypertension)	
Cancer	
Ulcers (stomach, esophagus)	
Thyroid disease (e.g. Hashimoto's Thyroiditis, Thyrotoxicosis, Graves' Disease, Hypothyroidism)	
Hormonal related issues (e.g. Premenstrual Syndrome, Menopause)	
Blood clotting problems (e.g. Thromboembolism)	
Lung Condition (e.g. Asthma, Emphysema, COPD)	
Kidney Condition (e.g. Kidney Stones, Acute Renal Failure, Renal Arterial Stenosis)	
Liver Condition (e.g. Jaundice, Cirrhosis, Hepatitis,)	
Skin Condition (e.g. Atopic Dermatitis, Contact Dermatitis, Seborrhea)	
Diabetes	
Arthritis or joint problems (e.g. Osteoarthritis, Rheumatoid)	
Depression	
Epilepsy	
Headaches/migraines	
Eye Disease (e.g. Glaucoma, Cataracts)	
Other:	
Have you been admitted into the hospital, or visited the emergency room, in the past 2 years? NO YES If YES, please describe:	
Are there any other problems that you feel need attention, but have not been mentioned above? ______________________________ What would you like to achieve as a result of your sessions with the pharmacist?	